WESTERN HIGHLANDS NETWORK FINANCIAL AND RELATED REVIEW

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

JULY 23, 2012

FINAL AND CONFIDENTIAL

Government Human Services Consulting

CONTENTS

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Introduction

Purpose and Background

This report summarizes the findings of the Western Highlands Network (WHN) Financial and Related Review (Review). The Division of Medical Assistance (DMA) asked Mercer Government Human Services Consulting (Mercer) to perform a financial and related review of WHN, in collaboration with DMA staff, to enhance continuity between the Mercer approach and any follow-up provided by DMA. DMA and Mercer conducted an ad-hoc review of WHN July 10 through July 12, 2012. This report details findings and action items from that review.

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Review Findings and Recommendations

This section of the report highlights the key findings and recommendations. The findings are based upon Mercer's review of materials, observations and discussions with WHN staff. The findings and observations will be separated by key functional areas (financial, clinical and information technology and claims). In addition, given the critical nature of management reporting for the operation of a managed care organization, a separate section focuses on the reports that WHN needs to develop as soon as possible. As such, the remainder of this section and the report will discuss the following topics:

- Management reporting
- Financial operations
- Information technology and claims
- Clinical operations
- Next steps

1. Management Reporting

1a. Finding: The management reporting outputs of WHN do not provide WHN the ability to
effectively manage care and finances as an efficient organization for Medicaid operations.

RECOMMENDATION: WHN needs to develop a management reporting package that allows the organization to identify potential risk factors and areas of opportunity. The following reports highlight key areas that must be reviewed, at least monthly, based on date of service and/or process date appropriately to review across months:

• Reporting by category of service (category of service should be consistent with rate development):

– Number of unduplicated users

– Cost per unduplicated user

– Number of units per unduplicated user

– Cost per unit

• Per member per month and per unduplicated user per month income statement by category of service

• Inpatient and residential statistics:

– Number of discharges/admissions

– Average length of stay

– Average cost per discharge

– Readmission within 30/60/90 days

– Number of members in inpatient/residential

• Actual to budgeted statistics for the above categories

Note: As WHN progresses towards an efficient managed care entity, it should perform the above reporting at a funding source/category of aid level.

1b. Finding: The management team at WHN does not meet to discuss key management reports.

RECOMMENDATION: WHN needs to conduct weekly meetings across its key management team to discuss management reports. These meetings should result in action items to direct change within the organization. For example, if it is identified through review of management reports that there is an increase in the number of recipients in emergency departments, the

management team would identify this issue and meet to discuss opportunities to shift members to less costly levels of care while maintaining appropriate services.

1c. Finding: Operational units do not have power users to analyze data on a timely basis.

RECOMMENDATION: WHN needs to develop power users to analyze data on a timely basis within operational units. Even though the development of system-generated reports should remain within the information technology area, operational units must have access to the data warehouse (SQL server) to run queries and provide ad-hoc analysis on a timely basis. For managers that have Microsoft Access experience, this would be minimal training to query and analyze data for internal monitoring. For those without specific experience, staff would need additional training in SQL software tools. Since the SQL server is a read-only copy of the data in Netsmart, the users cannot change data.

The claims and reconciliation staff should, at a minimum, have the capability to review claims data to correctly deny or recoup inappropriate payments for the following reasons:

• Claims still pending after 30 days

• Claims without any status (e.g., pend, deny, accept) in the system

• Discrepancy in units processed. This could be various issues, not limited to the following:

– Provider billing issues, including direct data entry errors when the provider is entering claims directly into the WHN front-end system

– Units exceeding the maximum units per 24-hour day (e.g., 96 fifteen-minute units per day)

– Units exceeding procedure code maximum units per day (e.g., one room and board charge per day, etc.)

– Payments for units less than one (e.g., partial units or zero)

– Therapeutic leave (e.g., revenue code 0183) exceeding 15 days/quarter or 45 days/year)

• Missing primary diagnosis information in the data (at least 800 service lines are missing a primary diagnosis in the system)

• Validation of payment, including correct payment of emergency room services

• Accuracy of error codes used (e.g., benefits not in the plan versus included as part of a contractual arrangement)

• Validation of system edit accuracy (e.g., duplicate claims)

• Payments made for emergency room service without a primary diagnosis of 290–319

2. Financial Operations

2a. Finding: The incurred but not reported claims expense calculation does not provide an accurate estimation of Medicaid medical expenses on an accrual basis.

RECOMMENDATION: WHN must develop a methodology that correctly estimates incurred but not reported (IBNR) accrual and expenses. Given the technical nature of developing an accurate

methodology, WHN must determine if it needs to subcontract with an actuarial consulting or other management consulting firm to develop this methodology. In addition, WHN should submit a restated first quarter financial reporting package based upon the misstatement of its estimated Medicaid IBNR liability and medical expenses.

2b. Finding: WHN is operating at a projected loss and has identified action items to reverse this projected loss.

RECOMMENDATION: WHN should be placed on a financial corrective action plan that allows for weekly and monthly monitoring of its financial position by DMA. In addition, based upon weekly/monthly reporting submissions to DMA, there should be a monitoring call with WHN to discuss the current progress of the operations. The following information should be submitted:

• Balance sheet (monthly)

• Income statement by funding source (monthly)

• Paid claims summary (weekly after each claim system check run) – illustrates claims paid by month of service and month of payment

• IBNR claims liability by month of service (weekly after each claims system check run)

• Update and status of WHN plan for estimated savings (monthly) – also include any new initiatives implemented by WHN

• Additional reports as identified in 1a (monthly after development)

2c. Finding: WHN submitted reports to DMA that contained combined information for Medicaid and integrated payment and reporting system (IPRS) (state funded) dollars and utilization.

RECOMMENDATION: WHN should always treat the Medicaid data and IPRS information as separate due to the different funding sources. If reporting totals for both, there should also be separate information that indicates the Medicaid dollars and utilization separately. In many cases, it would also be helpful to understand the utilization patterns of 1915(b) versus 1915(c) waiver services – please see recommendation 1a (Management Reporting).

3. Information Technology and Claims

3a. Finding: System edits are still in the process of being developed. Some were implemented at different times in 2012.

RECOMMENDATION: Since WHN implemented the waiver program on January 1, 2012, the system should have all edits in place. However, as new edits are introduced, validation of the data should be performed to see if there are missed opportunities during the months prior to the edit being implemented.

Additional edits could be placed in the system to validate data, including:

• Service codes should contain only valid revenue codes (four digits) and Health Care Financing Administration common procedure coding system (HCPCS) codes or HCPCS/modifier combinations. Three-digit revenue codes, codes of PR, HC or codes containing special characters should not be present as a payable valid service code

• Primary diagnosis code should be within the range of 290–319xx or be automatically denied for certain services

• The form type should only be a C (professional) or U (UB)

• WHN needs to review all DMA publication bulletins to keep up with any changes in policy. For example, WHN has been allowing providers to bill H codes when providers should bill the appropriate CPT code

• Edits should enforce all current Medicaid policy (benefit) limitations

3b. Finding: Currently, there is no claims audit process in place to validate the accuracy of claims processed. WHN has recently started to perform focused audits based on potential issues.

RECOMMENDATION: WHN must develop and perform a claims audit process. Mercer recommends that 3% of all claims processed are audited for each processor, including the system auto adjudicated claims where no manual intervention is performed. Audits are intended to validate accuracy of claims payment, provide opportunities for claim processor training and find any system issues that need resolution.

3c. Finding: The claim adjustment process can be performed by voiding a partial payment. The system indicates the status as void instead of as an adjustment.

RECOMMENDATION: WHN should be able to adjust a claim, but the status should indicate an adjustment. This will be needed to distinguish what the original payment was and what the actual payment is after the adjustment. A distinct status code should be made to correctly identify pended, accepted and denied services, but also the initial claim, adjustment or void. This

will also be needed for accurate encounter reporting to the State Medicaid Management

3d. Finding: Multiple claims were manually processed with two check payments outside of the claim system in February 2012, totaling $63,471.96. The claims associated with these payments still have not been entered into the system. Without entering the claims into the system, there could be duplicates paid, and these dollars are not reflected in system reports.

RECOMMENDATION: WHN should process the claims associated with these payments to the hospital in the system. Verification should be made to ensure correct payment was made, that patients were actually eligible for services, that authorizations were correctly matched, that the claims do not have duplicate payments with those processed in the system and that additional system checks are not produced for these services.

3e. Finding: The system does not capture the complete date of service. WHN collects the statement header dates on institutional (UB and 837I) types of claims, but only one service date on the detail lines and professional claims.

RECOMMENDATION: Claim systems should be set up to capture header dates of service that encompass the “from” and “to” dates of service for all service lines within a claim. At a detail level, the “from” and “to” date of service should also be included. In many instances, the “from” and “to” date of service will be the same. This provides validation of the number of units to the service dates paid on the line, such as for inpatient details where multiple days are paid on one service line, or multiple detail lines are utilized for payment due to changes in room types (private to semi-private room).

3f. Finding: Authorizations in the system are not made based on the provider’s location where the services will be rendered. This allows the possibility that a provider with multiple sites could receive an authorization for a site that is not part of the contract. The claims system will deny services at the site that is not within the contract.

RECOMMENDATION: WHN’s system needs to contain the site where the service is being rendered in the authorization data so that claims payment can properly pay authorized services for Medicaid members with the provider contract.

3g. Finding: WHN process to identify a clean claim is a claim that was entered into the system without hitting any system edits. This does not match the expected definition by DMA.

RECOMMENDATION: Reports need to correctly identify clean claims as any claim that does not

require providers to submit additional information in order for the claim to be processed as an accepted or denied claim.

3h. Finding: Coordination of benefits handling is being done; however, WHN is not collecting data properly in their system. The actual payment made by Medicare was not captured, therefore, it could not be validated that the coordination was accurately performed.

RECOMMENDATION: WHN needs to capture the Medicare (and other insurance) payment information to ensure that the correct payment is being made on the claim, with Medicaid paying their allowable minus the primary carrier payment.

4. Clinical Operations

4a. Finding: While active care management is ongoing, clinical managers require routine utilization reports and access to the data sources for queries in order to manage care effectively and efficiently.

RECOMMENDATION: Implement the management reports identified in 1.a. above. Also, implement the following reports within 30 to 60 days, some of which are on WHN's list of reports pending development as noted by the number in parenthesis:

1. Daily census reports:

A. Adult and Child Inpatient (mental health/substance abuse (MH/SA) and intellectual disability/developmental disabilities (I/DD))

B. Child Psychiatric Residential Treatment Facility (PRTF)

C. Intermediate Care Facility for the Mentally Retarded

D. Emergency Room (ER) - Adult and Child (MH/SA and I/DD)

2. Treatment authorization requests (weekly):

A. Total number of treatment authorization requests (TARS) reviewed by care manager

B. Total TARS approved by care manager

C. Number of TARS reviewed in 14 days by care manager

D. Percent of TARS reviewed within 14 days by care manager

E. Average number of days to review a TAR by care manager

F. Caseload size by care manager and care coordinator (MH/SA & I/DD)

G. Number/percent of service denials by level of care

3. Consumer and Family Grievances (Adult/Child, MH/SA, I/DD by county)

4. Top 20% Cost by Consumer Report (#75)

5. Continuity of Care – Follow up After Discharge from a Community Crisis Service (#305)

6. Continuity of Care – Follow up After Discharge from a Community Psychiatric Hospital Bed

7. Average Length of Stay in ER Setting

8. ER Setting Dispositions (inpatient, home, homeless shelter, etc.)

9. Inpatient Recidivism Report by consumer, by facility

10. Service utilization reports (by level of care, consumer, county)

4b. Finding: Transitional authorizations by ValueOptions (VO) for PRTF and other high cost intensive services do not appear to be consistent with DMA policy, resulting in PRTF
authorizations beyond 30 days and more, typically for six months to one year for PRTF and other services, such as assertive community treatment (ACT) and community support team (CST). WHN believed they had to honor these authorizations per the transition plan.

RECOMMENDATION: Clarification by DMA of authorization timeframes and length of current transitional authorizations. WHN plans to review placements of all children and youth in PRTFs and other high-cost services. Continue positive efforts resulting from WHN study to transition children and youth with conduct disorders into more appropriate settings. Continue efforts to review appropriate utilization of ACT and CST services for adults.

4c. Findings: Care management/utilization management (CM/UM) and care coordination staff rely on paper processes to manage care and workflow. For example, care coordinators must go through each record to determine if person-centered plans were completed and timely. CM/UM maintains TARs in hard copy in a locked file due to lack of confidence in the validity of the data in the system. The information system does not have prompts or flags for clinical management staff to notify them of pending items.

RECOMMENDATION: Assess the capability of the information system and electronic medical record to support care management/coordination functions. For example, the system should provide staff with an automatic daily task list of key required activities, such as dates for re-reviews of inpatient stays, due dates for submission of requested information and completion of person-center plans, etc.

4d. Finding: The process for report development is cumbersome. Quality management staff meets with clinical managers to develop reports and then the reports are prioritized by senior management. Historically, clinical management reports are low priority, resulting from claims management and financial reporting challenges and the need to focus resources on provider payments. However, this has left clinical management staff with gaps in information necessary to manage care effectively and efficiently.

RECOMMENDATION: Elevate priority for clinical management reports recommended in this report for completion within 30 to 60 days and allow senior clinical staff access to database for

data queries as indicated in 1c above.

4e. Finding: The outpatient therapies authorization guidelines may result in over-utilization of outpatient individual, group and family therapies. WHN utilizes their experience with management of state-funded services for authorizing a Medicaid package of outpatient services (individual, family and group therapy) based on LOCUS or CALOCUS scores, American Society of Addiction Medicines criteria and other clinical information. While the WHN care managers review 100% of all treatment requests, the authorization of a "package of services" that includes up to 312 events/services per year may result in the routine authorization of an excessive number of services.

RECOMMENDATION: WHN should consider suspending the authorization of Medicaid packages for outpatient services until the care management system is fully functional, and clinical staff has access to accurate, timely CM/UM reports to support the management of care. As a new managed care organization, care mangers will then have more opportunities to engage providers, requesting additional services to ensure appropriate alternative services, such as dialectical behavioral therapy or intensive outpatient programs based on the individual's clinical presentation. A policy focusing on use of the outpatient authorization guidelines should be developed to orient new staff on their use and to prevent automatic authorization of the maximum number of services.

5. Next Steps

Mercer recommends establishing weekly meetings during the next 30 to 60 days to discuss WHN's progress on implementing the recommendations in this report, utilizing the intradepartmental monitoring team (IMT). The IMT meetings should continue at least monthly, with the frequency determined by DMA based upon progress. In addition, action items and recommendations contained within this report must be implemented by WHN within 90 days.